ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted]**senior partner, Eltham Palace Surgery, 20 Court Yard, Eltham, SE9 5QA.**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner London South.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 16 October 2012 I commenced an investigation into the death of Philip Allen. The investigation concluded at the end of the inquest on 20 October 2014. The conclusion of the inquest was that he died of natural causes. The medical cause of death was vascular dementia.
4	**CIRCUMSTANCES OF THE DEATH** Philip Allen was diagnosed with vascular dementia in 2009. In September 2012 following a deterioration in his condition he was transferred from The Oaks Care Centre to QEH where he died. Mr Allen was admitted to The Oaks on or around 6 June 2012. He was seen by [redacted] at that time a partner at Eltham Palace Surgery, who prescribed Quetiapine in addition to the Respiridone that Mr Allen was already taking. On 20 June 2012 Mr Allen was seen (at [redacted] by [redacted] consultant in old age psychiatry at Oxleas NHS Trust. [redacted] discontinued the Quetiapine and wrote to Eltham Palace Surgery accordingly. Despite this letter it appears that the Quetiapine continued to be prescribed to Mr Allen as a repeat prescription by Eltham Palace Surgery until September 2012. In evidence at the inquest [redacted] who has now retired from practice, stated that the matter had been investigated at Eltham Palace Surgery as an untoward incident but he was unable to give details of this investigation.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. –

	[redacted] as Mr Allen's GP, sought specialist advice from [redacted]. Not only was this advice not followed but the Quetiapine, which [redacted] had stopped, continued to be prescribed as a repeat prescription on several occasions. The evidence at the inquest was that the further prescriptions of Quetiapine did not contribute to the death. However, I am concerned that the system at Eltham Palace Surgery did not prevent the repeat prescription. [redacted] was unable to say if changes have been made since this incident.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as senior partner of Eltham palace Surgery have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 December 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: 1. Aston Brooke Solicitors, acting for Mr Allen's family. 2. Weightmans LLP, solicitors acting for Priory Group which operates The Oaks Care Centre. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**27 October 2014** **Philip Barlow**